
# TennCare Operational Protocol

# Chapter 2:
# Eligibility and Enrollment

## Section 2.1
## Overview of TennCare Eligibility

This chapter provides a description of the populations covered by TennCare. These include **Medicaid eligibles**, as well as **"demonstration eligibles."**

"Medicaid eligibles" are persons who meet the criteria for one of the Medicaid categories covered by the TennCare program. "Demonstration eligibles" are persons who do not meet the criteria for a Medicaid category but meet the criteria for one of the demonstration categories. These are persons who would not be eligible for Medicaid in the absence of the TennCare waiver, or demonstration. The two major demonstration groups are:

- uninsured children under the age of 19
- non-pregnant adults who meet criteria patterned after those of the Medicaid Medically Needy program.

The eligibility groups are summarized in Table 2-1 and listed in more detail in Special Term and Conditions (STC) #19.

It is important to recognize that a person must meet the criteria for a TennCare category in order to be eligible for the program. Medicaid categories are established by federal law, with some categories being **mandatory** for states and some being **optional**. The demonstration categories, which are not established in federal law, must be formally approved by CMS as part of the 1115 waiver. States do not have the option of simply choosing to cover certain people or certain groups of people without explicit federal approval.

**Table 2 - 1**
**Major TennCare Eligibility Categories**

| TennCare Categories | Brief Description |
|---|---|
| ***Mandatory Medicaid Categories*** | |
| 1931* recipients | Persons who meet certain criteria associated with the program that was formerly called Aid to Families with Dependent Children (AFDC), including people losing eligibility for welfare benefits due to income from employment or work hours or increased child or spousal support collections |
| Poverty level pregnant and postpartum women | Pregnant and postpartum women with incomes below 185% of poverty |
| Poverty level infants and children to age 19 | Infants to age 1 with incomes below 185% of poverty; children from 1 to age 6 with incomes below 133% of poverty; children from age 6 to age 19 with incomes below 100% of poverty |
| Children in foster care or adoption | |

| TennCare Categories | Brief Description |
|---|---|
| subsidy arrangements | |
| SSI recipients, including persons in SSI-related groups | Low income persons who are aged, blind, or disabled |
| ***Optional Medicaid Categories*** | |
| Institutionalized individuals | Persons receiving care in Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, or Home and Community Based waiver programs who have incomes below 300% of the SSI Federal Benefit Rate |
| Women under 65 who need treatment for breast or cervical cancer and who are not otherwise eligible for Medicaid | Women who have been screened at a site authorized by the Centers for Disease Control and Prevention and who have incomes that do not exceed 250% of poverty. |
| Medically needy pregnant women and children under age 21 | Pregnant women and/or children who have incurred enough unreimbursed medical bills to meet the state's spend down level. |
| ***Title XXI demonstration children[1]*** | |
| Uninsured children with incomes below 200% of poverty | Children who were either already eligible for TennCare or who "rolled over" after losing Medicaid eligibility and lack access to insurance. |
| ***Other demonstration eligibles*** | |
| Medically Eligible children who have incomes at or above 200% poverty | Uninsured children who were either already eligible for TennCare or who "rolled over" after losing Medicaid eligibility, who lack access to insurance, and who have been found to be Medically Eligible (uninsurable). |
| Standard Spend Down (SSD) enrollees | Adults age 21 and older who are not pregnant or post-partum; who are aged, blind, or disabled; and who have incurred enough unreimbursed medical bills to meet a "spend down" obligation similar to that of the Medicaid Medically Needy program or caretaker relatives of Medicaid-eligible children. |

*Section 1931 of the Social Security Act was established as part of the 1996 welfare reform law.

### 2.1.1 TennCare Medicaid Eligibility Groups

All persons who would be eligible for Medicaid under the eligibility rules specified in Tennessee's State Plan for Medical Assistance (provided in accordance with Title XIX of the Social Security Act) are eligible for TennCare.

Eligibility for Medicaid through the Supplemental Security Income (SSI) program is determined by the Social Security Administration (SSA). (SSI recipients are

[1] Title XXI is the State Children's Health Insurance Program. Certain uninsured children in TennCare who meet the SCHIP definition of a "targeted low income child" are counted as SCHIP children, even though they participate in TennCare.

automatically eligible for TennCare.) Eligibility for all other TennCare categories is determined by the Department of Human Services.

*Reference: See Rule 1200-13-13-.02(5) and STC #19.*

**Transition Group.** There are a number of non-pregnant adults who were enrolled in the Medicaid Medically Needy category when that category was closed in 2005. These persons have remained eligible for TennCare Medicaid, pending their assessment for the new SSD program that opened up in 2008. The persons in this group must establish eligibility either under an open Medicaid category or the SSD category, in order to remain eligible for TennCare. This group is described in STC #23.

*Reference: See STC #23 in the approved TennCare II waiver.*

**Financial eligibility.** Financial eligibility for Medicaid programs is generally determined based on "income" and "resources."

- **Income** means wages, pension payments, and similar sources of regular support. The family income level is calculated by DHS according to the current federal poverty level (FPL) standards, using definitions of "family" and "income" that are similar to those used for Medicaid applicants.
- **Resources** are assets such as cash, bank accounts, stocks, bonds, and property.

Many of the TennCare categories refer to incomes that are certain percentages of the Federal Poverty Level. The FPL is updated annually. A copy of the FPL for the current year can be found at http://aspe.hhs.gov/POVERTY/

### 2.1.2 TennCare Standard Eligibility Groups

The non-Medicaid Demonstration population for TennCare is the population enrolled in TennCare Standard. The following groups are included in TennCare Standard:

**Group 1: Uninsured low-income children.** These are children who are either already enrolled in TennCare Standard or who have lost Medicaid eligibility and have been able to transition to this group as "Medicaid Rollovers." They must lack access to insurance, be under age 19, and have family incomes that do not exceed 200% poverty. The children in Group 1 are considered SCHIP children[2] under the TennCare II extension. The costs of their services are paid for with Title XXI funds, rather than Title XIX funds.

*Reference: See Rule 1200-13-14-.02(5)(a)1.*

[2] Tennessee has a type of SCHIP program that is referred to as a "combination" SCHIP program. There is a stand-alone component, which is called CoverKids, and there is a Medicaid component, which includes the children in Group 2 who have incomes at or above 200% of poverty.

**Group 2: Uninsured Medically Eligible children**. These are children who are either already enrolled in TennCare Standard or who have lost Medicaid eligibility and have been able to transition to this group as "Medicaid Rollovers." They must lack access to insurance, be under age 19, and meet the criteria for the "Medically Eligible" category. There is no income limit. Generally, children in this group have incomes at or above 200% of poverty, since they could be covered in Group 1 if their incomes were below 200% of poverty.

*Reference: See Rule 1200-13-14-.02(5)(a)2.*

**Group 3: Grandfathered uninsured children.**[3] There are uninsured children who were eligible for TennCare as of December 31, 2001, even if they had access to insurance, but whose family incomes were below 200% poverty. In order to stay in this eligibility group, children must remain continuously enrolled, must continue to meet income standards, lack access to insurance, and be under the age of 19.

Group 3 is a "grandfathered" group from the TennCare waiver that ended in 2002. All of the persons in this "grandfathered" group will continue to be enrolled in TennCare as long as they are continuously enrolled in their "grandfathered" category and they continue to meet all program requirements. If there is a break in coverage for any reason, persons disenrolled from a "grandfathered" group will not be able to re-enroll in that group. They will be treated like new applicants if they apply again for TennCare. Persons in the "grandfathered" groups who become Medicaid-eligible will not be able to return to their "grandfathered" group when their eligibility for Medicaid ends. They will be allowed to apply for TennCare like other Medicaid Rollovers when their Medicaid ends.

*Reference: See Rule 1200-13-14-.02(5)(a)3.*

**Group 4: Standard Spend Down enrollees.** These are non-pregnant adults aged 21 or older who fall into one of the following groups: people aged 65 and older, people with disabilities, people who are blind, or caretaker relatives of Medicaid-eligible children. They must meet spend down criteria patterned after those criteria used in the Medicaid Medically Needy program.

*Reference: See Rule 1200-13-14-.02(6).*

**Discontinued Demonstration Group.** Within the Demonstration population, there is a group called the Discontinued Demonstration Group which consists of uninsured and/or Medically Eligible (i.e., uninsurable) adults aged 19 or older who were enrolled in categories that were terminated by the state in 2005. The individuals in this group are being assessed for eligibility in open Medicaid categories to determine their continued eligibility for the program. At some point in the future, there will be no persons in this group, since those who are eligible in other Medicaid categories will have been moved to those categories.

*Reference: See Rule 1200-13-14-.02(7) and STC #24.*

### 2.1.2.1 Technical eligibility criteria

[3] Children in this group are counted as SCHIP children, since their incomes are below 200% of poverty.

All members of the demonstration population must meet the following technical eligibility criteria: they must be residents of the State of Tennessee, be United States citizens or legal resident aliens, have met Social Security enumeration requirements, and not be incarcerated.

*Reference: See Rule 1200-13-14-.02(3).*

### 2.1.2.2 Access to insurance

"Access to insurance" remains an important concept in TennCare Standard. Persons in TennCare Standard other than those in the Standard Spend Down program must lack access to health insurance. The types of policies that count as "insurance" and the types of policies that do not count as "insurance" for purposes of determining uninsured status are presented in Attachment B.

*Reference: See Rule 1200-13-14-.02(3)(g).*

### 2.1.2.3 Financial eligibility

What is counted as "income" for children in TennCare Standard is the same as that for TennCare Medicaid children. (See Section 2.1.1.) Resources are not counted for TennCare Standard children.

Enrollees in the Standard Spend Down program have the same spend down levels and resource requirements as pregnant women and children served in the Medicaid Medically Needy program. They must "spend down" to the state's Medically Needy Income Standard ($241 for a family of 1; $258 for a family of 2; $317 for a family of 3; etc.). Their resources cannot exceed $2,000 for a family of 1 or $3,000 for a family of 2.

## 2.1.3 TennCare and Medicare Eligibility

Some Medicare beneficiaries are also eligible for cost-sharing and Medicare premium assistance from TennCare. Individuals who have Medicare and are also TennCare Medicaid-eligible are called "dual eligibles."

Categories of Medicare cost-sharing assistance are as follows:

- **Qualified Medicare Beneficiaries (QMBs).** These are Medicare beneficiaries whose Income is less than or equal to 100% of poverty. If they are also eligible in a TennCare category, they are called **QMB-Plus's.**
- **Specified Low Income Medicare Beneficiaries (SLMBs).** These are Medicare beneficiaries whose income is between 100% and 120% of poverty. If they are also eligible in a TennCare category, they are called **SLMB-Plus's.**
- **Qualifying Individuals (QIs).** These are Medicare beneficiaries with incomes between 120% and 135% of poverty. They are not eligible for TennCare.
- **Qualified Disabled Working Individuals (QDWIs).** These are Medicare beneficiaries whose income is less than 200% of poverty. They are not eligible for TennCare.

- **Other Medicare/TennCare duals.** These are Medicare beneficiaries who do not belong in any of the above categories but who also qualify for TennCare.

Information about what TennCare covers for each Medicare eligibility group is contained in Chapter 3, entitled "Benefits and Cost Sharing."

*Reference: See Rule 1200-13-.17.*

### 2.1.4 Aliens and Refugees

Legal aliens continue to be eligible for TennCare if they meet Medicaid eligibility criteria, and they are enrolled in MCOs and BHOs in the same manner as all other TennCare enrollees. Refugees have been eligible for eight months of Medicaid coverage after they arrive in the United States. Availability of this coverage ended on July 1, 2008. Refugees receiving Medicaid coverage on July 1, 2008 will be allowed to continue through their eighth month.

Emergency services for undocumented aliens continue to be provided as federally mandated.

*Reference: See the following Policy Statement:*

EED 05-001 – Eligibility and Services for Illegal/Undocumented Aliens
http://www.state.tn.us/tenncare/pol-policies.html

## Section 2.2
## TennCare Application Process

### 2.2.1 Overview: Applying for TennCare Medicaid

Persons meeting Medicaid eligibility criteria can enroll at any time. All applicants for TennCare, except SSI recipients and children in state custody, must complete a written application and be interviewed by a worker with the Department of Human Services (DHS). SSI applicants apply through the Social Security Administration (SSA) and are automatically enrolled in TennCare Medicaid upon approval of SSI benefits. Children coming into state custody are enrolled through the Department of Children's Services. They have access to an arrangement called "immediate eligibility," which is discussed in Section 2.2.7.

Pregnant women can apply for presumptive eligibility status at local health departments and other sites designated by the Department of Health through the Title V agreement.[4] If they meet the requirements, they become immediately eligible for 45 days of

[4] Title V of the Social Security Act is a federal-state partnership which authorized the creation of the Maternal and Child Health programs, thereby providing the foundation and structure needed to meet the nation's goals for healthy mothers and children. OBRA 1989 converted the Title V program into a block grant program, consolidating seven categorical programs.

TennCare coverage. They must follow up with applications through DHS in order to continue benefits past the 45-day period.

Women who are under age 65, who are uninsured or have insurance which does not cover treatment for breast or cervical cancer, and who have been determined to be in need of treatment for breast or cervical cancer may be screened for presumptive eligibility for Medicaid by a Centers for Disease Control and Prevention (CDC) site such as the health department. Presumptive eligibility lasts for a period of 45 days. During the presumptive eligibility period, the enrollee must go to the DHS office to complete her enrollment in Medicaid. The DHS worker first evaluates the woman to determine if she is eligible for any other Medicaid category. If she is not eligible in another Medicaid category, the worker evaluates her for this optional Medicaid category to cover her during the time she needs treatment for cervical or breast cancer. A redetermination of eligibility will occur at least every 12 months and will be based on the need for continuing treatment for breast or cervical cancer, as determined by the woman's treating physician.

Applicants other than SSI applicants usually complete a portion of the application prior to the actual face-to-face or telephone interview. During the interview, the DHS worker and the applicant(s) jointly complete the remainder of the application. Persons who are unable to complete the applicant sections of the full application are assisted by DHS workers during the interview process (see Section 2.2.9). Applicant information is keyed on-line during the interview (in most cases) or from a workbook manually completed by a DHS worker at a later time (only occasionally).

An online application is now available for people who want to apply for TennCare. It is accessible through both the TennCare web site and the web site for the Department of Human Services. Following the receipt of the electronic application, DHS will contact the applicant about scheduling an interview and any additional information that may be needed.

*For access to the on-line application:*
TennCare's website: http://www.state.tn.us/tenncare
DHS' website: http://www.tennessee.gov/humanserv/

The state's automated eligibility system (ACCENT) determines Medicaid eligibility by category based on the information entered. Medicaid eligibility is determined within the time periods provided for in federal regulations, and the applicant is notified by DHS of the result of this process. Appeals of denials of Medicaid eligibility are handled by DHS.

*Reference: See Rule 1200-13-14-.02(1).*

### 2.2.2 Overview: Applying for TennCare Standard

#### 2.2.2.1 Uninsured child eligibility

Children under age 19 whose Medicaid eligibility is ending are screened for TennCare Standard. If the applicant lacks access to insurance and has income below the specified poverty level, he may be eligible for the TennCare Standard Uninsured category. If the applicant meets all the technical eligibility criteria for TennCare Standard and is ineligible

solely because of excess income, the applicant is offered an opportunity to apply in the Medically Eligible (ME) category.

Uninsured children under age 19 whose Medicaid eligibility is ending but who qualify for TennCare Standard and who file timely applications will be allowed to move immediately into TennCare Standard as Medicaid Rollovers, assuming they meet the income and/or Medical Eligibility criteria in place at the time. They will not experience a break in coverage.

*Reference: See Rule 1200-13-14-.02(5)(c).*

### 2.2.2.2 Medical Eligibility

There are two options that an applicant may use to apply for Medical Eligibility. Both of the processes begin with an eligibility determination at the local Department of Human Services. Any child under age 19 whose Medicaid eligibility is ending, who is uninsured, and who meets all of the technical requirements for TennCare Standard but has income at or above 200% of poverty will be given an opportunity to apply as Medically Eligible by completing a special packet. The options for Medical Eligibility are shown in Table 2 – 2.

*Reference: See Rule 1200-13-14-.02(5)(c)2.*

**Table 2 - 2**
**Options for Medical Eligibility**

| Options | General Description |
|---|---|
| **Qualifying Medical Condition** | The applicant must either have his physician attest that he has a medical condition on the TennCare list, *or* the applicant must submit, along with the completed application, appropriate medical records to support the attestation of a medical condition *not* included on the TennCare list, and a release for additional medical records, if necessary. |
| **SED** | The applicant must have a current (within the past 12 months) assessment as SED (Seriously Emotionally Disturbed). He must provide attestation by a licensed mental health professional of the diagnosis that supports the basis for the TPG assessment, as well as the medical records to support that diagnosis.<br><br>TennCare will review available encounter data and, if the encounter data shows that the person has been assessed as SED within the past year, he will not be required to submit additional medical information. |

For Option 1 ("Qualifying Medical Condition"), TennCare has prepared a list of diseases/conditions that will be used to determine Medical Eligibility (see Attachment C). The diseases/conditions selected represent serious and/or chronic conditions requiring continued monitoring and/or treatment. Due to the serious nature of these diseases/conditions, most Tennessee insurance companies will deny coverage to individuals with a medical history that includes one or more of these diseases/conditions.

"Medical records" are defined in *Tennessee Code Annotated (T.C.A.)* 63-2-101(c)(2) as "medical histories, records, reports and summaries, diagnoses, prognoses, records of treatment and medication ordered and given, x-ray and radiology interpretations, physical therapy charts and notes, and lab reports." Applicants for Medically Eligible status are not required to submit all the medical records they may have. Rather, they are required to submit a copy of a current medical record or portion of a medical record that documents the existence of the medical condition they have said that they have. A lab test may be sufficient in some circumstances. However, the lab test cannot be "anonymous" — it must be clearly identified as belonging to the person applying for Medically Eligible status.

Each of the methods above requires the applicant to include with the completed application all supporting documentation. Only complete applications accompanied by the required supporting documentation will be processed.

Medically Eligible TennCare Standard enrollees must renew their TennCare eligibility on the same schedule as other TennCare enrollees. Renewing TennCare eligibility means updating information on income, family size, access to insurance, etc. However, the medical criteria for Medical Eligibility will not be verified annually for those who remain on the program without a break in coverage.

*Reference: See Rule 1200-13-14-.02(5)(c)2.*

### 2.2.2.3 Standard Spend Down eligibility

The SSD eligibility category is designed for a certain number of non-pregnant/postpartum adults aged 21 or older who are caretaker relatives of Medicaid-eligible children, or aged, blind, or disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the Medicaid State plan.

*Reference: See Section 2.1.1.*

The Bureau is presently in the process of reviewing the eligibility of those adults in the Transition Group (see Section 2.1.1) to determine the enrollees' eligibility for SSD. Once this process is completed, the State will announce a series of "open enrollment" periods for those who wish to apply.

DHS will establish a telephone "Call-In Line" as a single point of entry for those who think they may qualify as SSD. Calls will be accepted up to the point that DHS estimates it can process applications within Federal timeliness standards. Callers to the Call-In Line will be asked for simple demographic information and will be assigned a unique identifier. A match will be done to determine if the caller is already enrolled in TennCare Medicaid. If not, an application form with a letter instructing the caller to complete the form and return within 30 days to be considered for enrollment will be mailed. Callers who are determined to be already enrolled in TennCare Medicaid as Medicaid state plan eligibles will be sent a letter informing them that they currently have benefits and that they do not need to apply. Additional information about enrollment in TennCare Standard Spend Down is found in Part III of Section XII of the STCs.

*Reference: See TennCare II approved waiver – Section XII Part III and Rule 1200-13-14-.02(6).*

### 2.2.3 Effective Date of Eligibility

See Table 2 – 3.

**Table 2 - 3**
**Effective Date of Eligibility for TennCare**

| Program | Eligibility Category | Effective Date of Eligibility |
|---|---|---|
| TennCare Medicaid | SSI eligibles | The date determined by the Social Security Administration in approving the individual for SSI benefits |
| TennCare Medicaid | All other Medicaid eligibles | The date of the application,* or the date of the qualifying event (such as the date that a spend down obligation is met), whichever is later. |
| TennCare Medicaid | Presumptively eligible pregnant women or women who have been found to need treatment for breast or cervical cancer | The date an application is approved at the Department of Health or at any alternative sites designated by the Department of Health. |
| TennCare Standard | Uninsured children under 19 | The day following the close of the Medicaid segment of the individual's eligibility. |
| TennCare Standard | SSD eligibles (Transition Group—see Section 2.1.1) | The date of application or the date that spend-down is met (must be met by the end of the month that an application is received by DHS) |
| TennCare Standard | SSD eligibles (Call-in Group—see Part III of Section XII in the STCs) | The date the call was received by DHS, assuming the person is ultimately determined eligible, or the date the spend down is met, whichever is later. The latest date by which spend down can be met is the end of the one-month budget period – in this case, the end of the month of the original call to the Call-In Line. |

*The date of application for Medicaid is:

- The date a signed application form is received in the county DHS office. The "begin date" for Medicaid is the application date or the date all eligibility requirements are met, whichever is later (example: a child applies for Medically Needy coverage but does not meet "spend down" until two weeks after the application date) or

- The date a faxed application is received at DHS. Eligibility begins either the date of the fax or the date all eligibility requirements are met, whichever is later.

*Reference: See Rule 1200-13-13-.02(5)(b).*

### 2.2.4 Length of Eligibility Period

Once eligibility is established, it proceeds until a redetermination occurs. There are certain categories of eligibles that have automatic eligibility periods. These are as follows:

- **Pregnant women and newborns.** These women have TennCare Medicaid coverage for the length of their pregnancy, plus two months postpartum. The newborn is automatically given one year's eligibility in TennCare Medicaid if the mother was TennCare Medicaid-eligible on the day of birth. The newborn is placed in the same MCO as the mother unless the mother is in TennCare Select. In that situation, the child goes through the random assignment process.

- **Women receiving treatment for breast and/or cervical cancer.** These women remain eligible until treatment is no longer necessary, as determined by her physician, or she turns 65 years old. Annual eligibility reviews are done based on information from the woman's physician that continued treatment is needed for breast and/or cervical cancer. TennCare's Office of the Chief Medical Officer is responsible for reviewing the information submitted by the woman's physician.

- **SSI beneficiaries.** Those individuals who are enrolled in TennCare Medicaid because they receive SSI benefits from the Social Security Administration remain TennCare-eligible for as long as they are eligible for SSI.

- **Medically Needy and SSD enrollees.** These enrollees get an automatic year of eligibility.

Changes in income, family status or living circumstances (including address changes) that occur in the interim periods between "begin" and "end" dates of coverage must be reported by the enrollee to his DHS worker within 30 days, in accordance with *T.C.A.* 71-5-110. Failure to report such changes in a timely manner may result in termination from the program.

*References: See Rules 1200-13-13-.02(5) and 1200-13-14-.02(5) & (6).*

### 2.2.5 Re-Establishment of Eligibility

Eligibility in all TennCare categories will have a "begin date" and an "end date." A person may remain on TennCare past his end date only if he is determined eligible through the redetermination process. All TennCare enrollees must re-establish their ongoing eligibility for TennCare on at least an annual basis. *Ex parte* reviews conducted by DHS, responses to Request for Information (RFI) notices, and/or interviews between the DHS worker and the enrollee are the means by which this is accomplished. Enrollees will be required to provide updated information on their employment, income, assets, family status and other pertinent issues.

The determination that an individual meets the medical criteria for Medical Eligibility for TennCare Standard will not be reverified every year, since most of the conditions are chronic conditions that are life long. However, people who are Medically Eligible will still have to renew their TennCare coverage each year and provide updated information on residency, changes in income, and access to group health insurance.

### 2.2.6 Rollover Eligibility for Individuals under Age 19

If an enrollee under the age of 19 loses eligibility for TennCare Medicaid, he may apply for TennCare Standard and, if eligible, be enrolled in TennCare Standard without a break in coverage, unless the loss of eligibility is due to incarceration or non-resident status. People who enroll in this way are called “Medicaid Rollovers.” (Persons who lose eligibility because they are incarcerated or who move permanently out-of-state are not eligible to continue on TennCare as "Medicaid Rollovers.")

Enrollees who are children under the age of 19 moving from Medicaid to TennCare Standard will receive the same benefits as were included in their TennCare Medicaid benefit package. Thereafter, these enrollees must reestablish eligibility for TennCare Standard at announced intervals, which will occur at least once within a 12 month period.

*Reference: See Rule 1200-13-14-.02(5)(c).*

### 2.2.7 Presumptive Eligibility and Immediate Eligibility

**Pregnant women.** Presumptive eligibility for pregnant women is determined consistent with the standards and criteria followed by Tennessee Medicaid and in accordance with its approved Medicaid state plan. Presumptively eligible pregnant women have 45 days to complete the full eligibility determination process. During the presumptive period, the woman is considered to be a "temporary" Medicaid enrollee; if she does not go to DHS and become eligible in a Medicaid category, she will not be permitted to stay on TennCare when her presumptive period ends.

**Women needing treatment for breast and/or cervical cancer.** There is also presumptive eligibility for certain uninsured women identified by a CDC (Centers for Disease Control and Prevention) site as requiring the need for treatment for breast or cervical cancer. Women who are under age 65, who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, and who have been screened at a CDC site and determined to be in need of treatment for breast or cervical cancer, may be determined to be presumptively eligible for Medicaid at the CDC site. They then go to their county DHS office for determination of eligibility beyond the 45-day presumptive period. Coverage in this category is limited to the period during which a woman requires treatment for the breast or cervical cancer. Coverage is provided to these women who would not otherwise be eligible for Medicaid.

**Children.** There is no presumptive eligibility for children, except that children entering state custody are deemed “immediately eligible” for TennCare while their TennCare applications are being processed. Should the result of the eligibility determination

process be that the children are not eligible for TennCare, DCS will reimburse TennCare Select for any dollars spent on these children's behalf.

**HCBS applicants.** There is also an immediate eligibility process for persons applying to enroll in the Statewide Home and Community Based Services (HCBS) for the Elderly and Disabled program as set forth in State Rule 1200-13-1-.02(5). This allows an individual to begin receiving home and community based long-term care services sooner than he otherwise would, in order to avoid institutionalization. To qualify for immediate eligibility, a person must be applying for enrollment into the Statewide HCBS waiver program, be determined by TennCare to meet eligibility criteria for admission to a Level I Nursing Facility (i.e., have an approved Pre-Admission Evaluation (PAE)), have submitted an application for financial eligibility determination to DHS, and be expected, based on preliminary review of financial information, to qualify for TennCare Medicaid. If the result of the eligibility determination performed by DHS is that the person is not eligible for TennCare Medicaid, any long-term care services provided will be reimbursed with state funds, and FFP will not be claimed.

*Reference: See Rule 1200-13-13-.02(1)(e).*

### 2.2.8 HIPAA Statement of Coverage

Enrollees losing eligibility for TennCare Standard are provided with a Certificate of Creditable Coverage, as required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended. Persons who are denied TennCare Standard eligibility will receive timely notice of their denial and appeal rights.

Individuals who voluntarily terminate their TennCare coverage will also be provided with a timely Certificate of Creditable Coverage. Should the former enrollee need an additional HIPAA Certificate(s), he may request one by calling the Family Assistance Service Center (FASC) at 1-866-311-4287.

### 2.2.9 Newborns

TennCare coverage is automatically granted to any infant born to a Medicaid-eligible mother, effective on the date of birth. It is also granted, on the date of birth, to any infant born to a TennCare Standard-eligible mother if the TennCare Standard category in which the mother is enrolled is open for enrollment. The newborn will automatically be assigned to the same MCO as the mother, unless the mother is enrolled in TennCare Select. In that event, the newborn will go through the random assignment process. Parents or family representatives must take steps to get the infant enumerated for Social Security purposes, however, so that he will not fail the TennCare technical eligibility requirement that every enrollee have a valid Social Security Number.

For newborns, a hospital worker may provide to the mother, family member, or a family representative an SS5 Form (which is an application for a Social Security number/card) to complete for the purpose of obtaining a Social Security number for the newborn. The hospital worker or a DHS worker may assist in completing the SS5 Form. DHS is allowed to bypass the requirement that the newborn be enumerated if there is verification that an SS5 Form has been completed.

The MCO in which the mother is enrolled at the time of delivery will be responsible for the coverage and payment of all TennCare-covered services provided to the newborn, beginning at birth. Infants on TennCare Standard are automatically assessed for potential Medicaid eligibility at the mother's next annual visit at DHS for re-establishment of eligibility. New mothers may voluntarily present to their DHS worker for an assessment of Medicaid eligibility for their child at any time and, in fact, are encouraged to do so.

When a pregnant woman who is an undocumented alien qualifies for TennCare payment of the delivery of her newborn, the newborn is deemed eligible for one year of Medicaid coverage as long as the baby remains with the mother.

*Reference: See DHS Rule 1240-3-2-.02(h).*

## 2.2.10 Procedures for Accommodating Persons with Other Disabilities and Limited English Proficiency

For the past six years, the Bureau's Division of Member Services has been meeting with various consumer advocacy groups and other interested individuals to continue a dialogue about TennCare and enrollee issues, especially those issues involving reaching enrollees with disabilities or limited English proficiency. These are issues that are important to both TennCare and the advocates. This group meets regularly to discuss advocacy/outreach issues. Such meetings continue to benefit both sides by providing a better understanding of the issues involved and improving communications with the TennCare enrollee population.

### 2.2.10.1 Individuals with limited English proficiency (LEP)

Both the Bureau of TennCare and the Department of Human Services have made a number of provisions to assist individuals with LEP as they navigate the TennCare eligibility processes.

Both agencies have applications available in English and Spanish. In addition, TennCare mails notices in English and Spanish, and DHS mails notices in English or Spanish, depending upon what the individual has indicated is his primary language. An insert in each mailing provides a toll-free phone number that individuals may call for assistance with translation. These inserts have this information in Arabic, Somali, Kurdish-Badinani, Kurdish-Sorani, Bosnian, and Vietnamese. In addition, all notices contain the number of the Family Assistance Service Center. Through that number, a connection can be made with the AT&T Language Line for translation services, if necessary.

The Bureau of TennCare also maintains a contract with Health Assist Tennessee (HAT), an advocacy organization that provides outreach and advocacy assistance to persons with limited English proficiency, as well as translation services to TennCare enrollees and applicants. HAT can also direct enrollees and applicants to local community translation resources.

The Department of Human Services (DHS) also provides translation services, through bilingual staff, a contract with the AT&T Language Line, and through contracted and volunteer community translators.

Both the Bureau of TennCare and DHS maintain access to text telephones for the hearing impaired, and DHS also has sign language interpreters and readers for the visually impaired on contract.

#### 2.2.10.2 People with physical and other disabilities

The following strategies are in place to assist clients with a wide range of disabling conditions that might interfere with their ability to understand the eligibility process.

DHS has been performing eligibility determinations for Medicaid, Food Stamps, and its Families First program for many years. The Department has a lengthy list of accommodations that it has made and will continue to make available to the TennCare population. These accommodations include:

- Letting the enrollee/applicant designate a third party to represent him during the eligibility determination process;
- Conducting the interview with an individual over the phone;
- Conducting the interview at an alternative site that is easier for the enrollee/applicant to access;
- Conducting the interview outside of normal working hours; and
- In extreme cases, conducting the interview in the enrollee's home.

### 2.2.11 MEQC

TennCare has a contract with the Department of Human Services to conduct alternative Medicaid Eligibility Quality Control (MEQC) Projects for both Medicaid and Standard enrollees.

For TennCare Medicaid cases, Tennessee operates a pilot program that conducts focused reviews to determine the accuracy of Medicaid eligibility decisions made by DHS. Review findings are used by management staff to detect error trends and determine training needs, policy clarifications and corrective action needs. Cases are randomly chosen from all Medicaid cases containing families and children and reviewed for all eligibility factors. Recipient interviews are conducted by telephone.

For TennCare Standard cases, using six-month sampling periods, from April through September and from October through March, reviews of various groups in the TennCare universe will be conducted using monthly random samples from two groups of non-Medicaid eligible cases. The first group includes all active cases including Medicaid rollovers, uninsured people, and uninsurable people currently in the system. These cases will be surveyed in order to determine if each was eligible for services during all or part of the month under review, and if appropriate, whether the proper amount of recipient liability was computed. The second group includes negative case reviews, including all termination cases and denied applications. These cases will be surveyed to determine if the reason for the denial, suspension, or termination was correct and if

requirements for timely notice of negative action were met. The negative case sample size will be determined on the basis of the number of negative case actions in the universe.

In order that statistically valid statements can be made for the two sub-groups of the population, DHS will randomly draw 1,000 cases (2,000 total cases) from each group of the TennCare population every six months. From that, 30 cases from each group (60 total cases) would then be randomly sampled each month. Data will be collected using a questionnaire developed specifically for each of the two case types being reviewed. Additionally, letters will be sent to TennCare members with requests for collateral verification of certain types of information. Reviews of information from additional databases will also be utilized as necessary. In the unlikely event that a home visit is deemed necessary, it is expected that DHS would provide appropriate personnel to carry out this function.

At least annually, the state is required to submit a plan for a MEQC pilot project to the CMS Regional Office. When each pilot is complete, the state is to send a report to the CMS Regional Office, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy. This is done in compliance with STC # 26.

## Section 2.3
## Enrollment Process

### 2.3.1. Procedures for Enrollment into MCOs

At the time the application for TennCare is completed, the applicant selects a Managed Care Organization (MCO) from among those available in his area. All family members in the same case must enroll in the same MCO, except for children eligible to enroll in TennCare Select. Individuals who are returning to TennCare after a lapse in eligibility will be reassigned to their former MCO if the lapse in eligibility has been for less than 63 days. This assignment is an initial assignment only; members are given 45 calendar days (inclusive of mail time) from the date of the letter informing them of their re-enrollment in TennCare to change MCOs if they wish. If the applicant is subsequently approved for TennCare Medicaid or TennCare Standard, enrollment in the MCO will be effective on the same day that coverage in the program becomes effective.

Applicants who fail to select an MCO at their DHS interview are assigned to one that is available in the area in which they live. MCOs issue identification cards to enrollees, and such cards are used to access services from MCO network providers. Once enrolled, TennCare eligibles have 45 calendar days (inclusive of mail time) from the date of the letter of their notification of MCO assignment to change MCOs if they are dissatisfied with their MCO for any reason. After the 45-day change period, enrollees can only change MCOs based on proof of hardship criteria (see Attachment E) or once during the annual redetermination visit. TennCare also permits changes to place all family members in the same MCO, unless one of the family members is in TennCare Select. The MCC Change Unit within the Division of Member Services reviews and issues decisions on MCO change requests related to medical or service access issues.

Immediately upon being notified of the enrollee's eligibility, each MCO is responsible for providing a Bureau-approved Member Handbook and a Provider Directory listing the providers participating in the MCO's network. The MCOs are also responsible for providing each enrollee with an individual identification card.

Attachment D lists the current MCOs with whom TennCare contracts for services to be provided to enrollees. In addition to the current MCOs (as of publication of this Operational Protocol), this Attachment shows the end dates of the MCOs which will no longer participate in TennCare and the start dates for the new MCOs to begin serving TennCare enrollees. This Attachment also lists the BHOs, Dental, and Pharmacy contractors participating in TennCare.

*Reference: See Rules 1200-13-13-.03 and 1200-13-14-.03.*

### 2.3.3 Procedures for Enrollment into BHOs

In the East and West Grand Divisions, TennCare Medicaid and TennCare Standard enrollees are automatically enrolled in the BHO that is paired with the MCO to which they belong. The BHO also issues identification cards, a Member Handbook, and a Provider Directory to its enrollees. (Note: Effective November 1, 2008, in West Tennessee, and January 1, 2009, in East Tennessee, the MCOs will be integrated like the MCOs in Middle Tennessee, and there will be no more separate BHOs, except for TennCare Select.)

In the Middle Grand Division, the MCOs are providing integrated health care that includes behavioral health and substance abuse services along with the medical services provided. There is no separate BHO for Middle Tennessee enrollees, except for those enrollees in TennCare Select.

*Reference: See Rules 1200-13-13-.03 and 1200-13-14-.03.*

### 2.3.4 Procedures for Enrollment into TennCare Select

TennCare Select is a special Managed Care Contractor that operates statewide to serve certain enrollees identified by TennCare. TennCare Select is not an MCC that an enrollee can choose; rather, the state assigns certain enrollees to TennCare Select. These enrollees include:

- Children who are eligible for SSI;
- Children in state custody and children leaving state custody for six months post-custody as long as the children remain eligible;
- Children in an institutional eligibility category who are receiving care in a Nursing Facility (NF), an Intermediate Care Facility for persons Mental Retardation (ICF/MR), or a Home and Community Based Services (HCBS) 1915(c) waiver;
- Enrollees living in areas where there is insufficient capacity to serve them.
- Enrollees living out-of-state temporarily.

SSI children and children in an institutional eligibility category can “opt out” of TennCare Select if they wish and choose another MCC that serves the area where they live. All the other groups must remain in TennCare Select even if they wish to choose another MCC. Additional information about TennCare Select is found in Section 4.1.2.

*Reference: See STC #37 and Rules 1200-13-13-.03(1)(b) and 1200-13-14-.03(1)(b).*

### 2.3.5 Procedures for Enrollment with the Dental Benefits Manager and/or the Pharmacy Benefits Manager

There is only one PBM and one DBM, so the state enrolls members with these contractors.

*Reference: See STCs # 35 and 36, and Rules 1200-13-13-.03 and 1200-13-14-.03.*

### 2.3.6 Procedures for Changing MCOs/BHOs

Enrollees are given their choice of health plans when possible. Once enrolled, the new enrollee may change MCOs (if an alternate plan is available) within the first 45 calendar days (inclusive of mail time) from the date of the letter of enrollment and MCO assignment. Thereafter, the enrollee must remain in the assigned MCO until he is given an opportunity to change MCOs during his next redetermination interview. Only one change is permitted per year unless the enrollee moves out of the area served by his plan or meets hardship criteria.

When an enrollee requests to change his MCO, the MCC Change Unit within the Division of Member Services reviews the request to change MCOs against the six "hardship criteria" (see Attachment E). If the six criteria are not met, a denial letter is issued, including the right to appeal the denial of the enrollee's request.

Enrollees, after requesting and obtaining the approval of the Bureau of TennCare, may be permitted to change enrollment to a different health plan. In the event an enrollee changes plans, the enrollee’s medical care will be the responsibility of the original health plan until the date that the new MCO assignment is effective.

An enrollee must change MCOs if he moves outside the MCO’s Grand Division and that MCO does not operate in the enrollee’s new area of residence. Until the enrollee selects or is assigned to a new MCO, his medical care is the responsibility of the original MCO.

IN the event an MCO withdraws from participation in TennCare and is no longer available, TennCare will randomly distribute the membership across the remaining plans available in the Grand Division. If the enrollee does not want the MCO that was randomly selected for them, the enrollee will have 45 calendar days (inclusive of mail time) from the date of the MCO assignment to change MCOs.

According to STC # 38, the following situations are not considered to be “hardships” for which an MCO transfer will be approved:

- The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as defined by the state):

- The enrollee claims lack of access to services but the MCO meets the state's access standards;

- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;

- The enrollee is concerned that a current provider might drop out of the plan in the future; or

- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network providers.

*Reference: See Rules 1200-13-13-.03(2) and 1200-13-14-.03(2).*

### 2.3.7 Procedures for Annual Notification of Members

In keeping with the notice requirements outlined in the federal managed care regulations at 42 CFR 438.10(f) and in their TennCare CRA, the MCOs are required annually to update and mail handbooks to those enrolled in their TennCare plan.

## Section 2.4
## Enrollee Marketing and Outreach Strategy

### 2.4.1 Marketing Activities and Restrictions

Marketing guidelines are included in the Managed Care Organization contracts. Key points are summarized below.

Each MCO must submit a detailed marketing plan, all marketing materials and a description of marketing activities to TennCare for review and approval prior to implementation or use. All written marketing materials must be worded at a reading level that does not exceed sixth grade and must be printed with a minimum font size of 12 points. Materials must be made available in English and Spanish and in the language of any other Limited English Proficiency group identified by TennCare that constitutes five percent of the TennCare population or 1,000 enrollees, whichever is less.

Written materials must be made available in alternative formats or appropriate interpretation services must be provided for persons with special needs.

MCOs are permitted to distribute approved material through mass media and through general activities that benefit the entire community, such as health fairs. Telephone calls, mailings or home visits to current enrollees are permitted only for the purpose of educating current enrollees about services offered by the MCO.

The following activities are prohibited:

- Use of materials or activities that mislead, confuse, defraud, or are unfair;
- Use of overly aggressive solicitation;
- Gifts and offers of material or financial gain as incentives to enroll;
- Compensation arrangements with marketing personnel that tie compensation to the number of persons enrolled;
- Direct solicitation of prospective enrollees; or,
- Use of independent marketing agents.

### 2.4.2 Monitoring of Enrollee Marketing Activities

TennCare MCC contracts specifically prohibit true marketing activities. TennCare uses the term “marketing” to mean member materials which includes any informational and outreach materials meant to familiarize enrollees with their TennCare benefits and how to use those benefits successfully. TennCare also permits MCOs to conduct various outreach activities like Health Fairs. Plans for these activities also require TennCare approval as part of marketing oversight. The primary focus of monitoring activities is to assure that marketing materials are clearly written and include content that is both correct and appropriate. If complaints are reported by applicants or enrollees, additional monitoring activities may include member surveys, random audits, or undercover observation of marketing activities. Each of these activities is described below.

#### 2.4.2.1 Review and approval of enrollee marketing plans and activities

As set forth in the Contractor Risk Agreement (CRA), MCCs must submit detailed descriptions of all proposed marketing activities as well as copies of all marketing materials to be used. These include: advertisement copy; brochures; posters; fact sheets; video tapes; story boards for production of videos; audio tapes; newsletters; telemarketing scripts; and any other forms of advertisement as well as other forms of public contact such as participation in health fairs.

The marketing plans and materials are reviewed to ensure that proposed activities are permitted under state and federal marketing guidelines. TennCare will approve, deny or return the plan with comments within 15 days. Once approved marketing materials have been produced, copies of the final product must be submitted to TennCare.

#### 2.4.2.2 Failure to adhere to contractual marketing guidelines

If TennCare believes that violations of the marketing guidelines have occurred, an informal investigation will be conducted and TennCare staff will determine the appropriate response. This response may include written warnings to the MCC, or initiation of corrective action.

MCCs are required to develop and implement corrective actions to remedy the marketing problem(s). Sanctions may be imposed until such time as the state is satisfied that the problem has been resolved.